



TENNESSEE BOARD OF DISPENSING OPTICIANS
227 French Lnding, Suite 301
Heritage Place Metro Center
NASHVILLE, TN 37243
LOCAL (615) 532-5157
TOLL FREE (800) 778-4123

1313-001-\$50
1313-006-\$15
\$65

APPLICATION FOR APPRENTICESHIP TRAINING IN OPHTHALMIC DISPENSING

INSTRUCTIONS

1. Complete this application, have it notarized, enclose a non-refundable check for Sixty-five Dollars (\$65) payable to the Board of Dispensing Opticians, and mail it to the above address.
2. Attach a notarized photocopy of your birth certificate to the application.
3. Attach a "passport" size photograph taken within the preceding twelve (12) months to the front of the application.

NAME _____
First Middle and/or Maiden Last

DATE OF BIRTH _____ SOCIAL SECURITY # _____

CURRENT HOME MAILING ADDRESS: _____
CURRENT PRACTICE ADDRESS: _____

HOME PHONE _____ WORK PHONE _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application. For the purpose of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice as an Apprentice Dispensing Optician"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate diagnosis (if necessary) and exercise reasoned judgment and to learn and keep abreast of development in the field;
 - b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.
3. **"Chemical Substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
5. **"Illegal Use of Controlled Substances"** means the use of controlled substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	YES	NO
Do you currently have a medical condition which in any way impairs or limits your ability to practice as an Apprentice Dispensing Optician with reasonable skill and safety?	—	—
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	—	—
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner, in which you have chosen to practice?	—	—
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether conditions should be imposed or whether you are not eligible for apprenticeship.)		
Do you currently use chemical substances?	—	—
If yes, do they in any way limit your ability to practice opticianry with reasonable skill and safety?	—	—
Are you currently engaged in the illegal use of controlled substances?	—	—
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	—	—
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	—	—
If you have ever held or applied for a license or certificate to practice as a Dispensing Optician in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	—	—
Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	—	—
Have you ever been rejected or censured by a Professional Association?	—	—
In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you?	—	—
b. Have you ever had settlement of any legal action rendered <u>against</u> you?	—	—
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	—	—
If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	—	—

CURRENT AND PREVIOUS OPTICIANRY WORK EXPERIENCE

EMPLOYER NAME, ADDRESS, AND TELEPHONE NUMBER	DUTIES PERFORMED	DATES EMPLOYED FROM & TO

AFFIDAVIT OF APPLICANT

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying statements and transcripts are true, complete and correct. I understand that any false or misleading information in or in connection with my application may be cause for denial or loss of my apprenticeship.

I further swear that I have read and understand the statutes and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them while registered in the apprenticeship program.

Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, _____.

Notary Public

Commission Expires _____
(Notary Seal)

DIRECT SUPERVISOR FORM

THIS FORM MUST BE COMPLETED BY YOUR CURRENT SUPERVISOR

Per Rule 0480-1-.14(2): Apprenticeship training must be supervised by a dispensing optician, optometrist, or ophthalmologist licensed by the State of Tennessee and who works on the premises where the apprenticeship training is conducted and the supervisor must be present at all times.

Full Name of Apprentice: _____

Name of Direct Supervisor/TN License No.: _____

Business Name: _____ Business Phone: _____

Business Full Address: _____

Licensed to Practice as: _____ Dispensing Optician _____ Optometrist _____ Ophthalmologist

Name of Dispensary Where Training Will Occur: _____

Describe the type of facility where the apprentice will train in the space provided below:

Is the facility equipped with the recommended minimum equipment as stated in Rule 0480-1-.14(c)(1) and (2)? Yes ____ No ____
If not, how will apprentice achieve full training?

I request that _____ be registered under my supervision.
(Applicant)

I, _____, being duly sworn, depose and say that to
(Supervisor)
the best of my knowledge and belief, the statements made in this application are true and correct.

Signature of Supervisor

Subscribed and sworn to before me this the _____ day of _____, 20_____.

Signature of Notary Public: _____ My Commission Expires: _____

Return this form to:
BOARD OF DISPENSING OPTICIANS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

APPRENTICESHIP TRAINING IN OPHTHALMIC DISPENSING **SEMI-ANNUAL EVALUATION FORM**

Length of Training Program – Pursuant to T.C.A. §63-14-103(a)(10): The period of apprenticeship training must be a minimum of three (3) Years and must include a total of five thousand two hundred fifty (5,250) hours of full time or part time education and training under qualified supervision.

Semi-annual evaluation periods begin six (6) months from the initial registration and six (6) months thereafter until completion of the required training period. Make as many copies of this form as necessary.

The filing of these forms is **mandatory**. You will not receive reminders to submit this information. This is your responsibility. If these forms are not filed semi-annually, you will be considered not actively pursuing licensure and your application will be closed and you will be required to reapply and pay all fees.

Once you have completed a total of 5,250 hours of education and training under qualified supervision, you will be sent a letter, an application, and a copy of the rules and regulations stating that you may apply for licensure. If, for any reason, you are not able to apply for licensure at that time, you are still considered to be in apprenticeship training and semi-annual evaluations forms must continue to be submitted to this office. Failure to do so will result in your apprenticeship file being closed. You will be required to complete a new apprenticeship application, pay the fee, and begin a new period of 3 year apprenticeship training.

Please remember, your apprenticeship date begins the date you receive confirmation from the Board. All 6 month evaluations must reflect these dates. If there is a break, a letter must be issued to the Board stating the reason for the break.

Mail to: **BOARD OF DISPENSING OPTICIANS**
 227 French Landing, Suite 300
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 Nashville, TN 37243

Apprentice Name: _____

Mailing Address: _____

Home Phone: _____ Office Phone: _____

Name of Dispensary: _____

Current Practice Address: _____

_____ has worked _____ hours per week. Cumulative hours since beginning apprenticeship: _____ Duties listed below should be given percentages of time performed on each during a normal work week. Total percentage must account for 100% of work time.

% OF TIME	DUTIES PERFORMED
	Fitting and adjusting lenses to human faces.
	Fitting contact lenses.
	Interpreting prescriptions and making optical calculations.
	Verifying.
	Optical laboratory work (mechanical).
	Selling merchandise (Other than ophthalmic materials.)
	Stock work.
	Office work.
	Describe other duties not listed.

Supervisor's Signature/Title: _____ Date: _____

Evaluation period began on _____ and ended on _____.

MS/G4017188/DPO